

11919

CERTIFICATE OF DEATH

11916

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Worcester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Worcester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pocomoke City		c. LENGTH OF STAY IN 1b 8 months	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 812 Second Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Lidia Middle O. Last Bunting		4. DATE OF DEATH Month October Day 1 Year 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 26, 1873
9. AGE (In years last birthday) yrs. 84		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY --	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Smith Onley		14. MOTHER'S MAIDEN NAME Elizabeth Stant	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs Dorsey Wessells, Pocomoke City, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) Arteriosclerosis, generalized DUE TO (c) years			INTERVAL BETWEEN ONSET AND DEATH 1 Week
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Mar. 56 to Oct. 1 , 19 58 , that I last saw the deceased alive on Sept. 30 , 19 58 , and that death occurred at 3:30 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Charles W. Trader		ADDRESS (Street, city or town, state) DATE SIGNED 302 Market St., Pocomoke City, Md. 10-1-58	
PHYSICIAN'S NAME (Type) Charles W. Trader			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-3-58	
22c. NAME OF CEMETERY Bethany Methodist		22d. LOCATION (City, town, or county) (State) Pocomoke City, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Henry H. Watson		24a. REC'D BY REGISTRAR OCT 6 '58	
ADDRESS Pocomoke, Md.		24b. REGISTRAR'S SIGNATURE Carlton S. K...	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH		6. OCCUPATION		7. CAUSE OF DEATH		8. PLACE OF DEATH		9. TIME OF DEATH		10. SIGNATURE OF REGISTRAR	
JAMES J. JONES		Male		45		1910		New York City		Teacher		Heart Disease		New York City		10:00 AM		J. J. Jones	
11. MARITAL STATUS		12. EDUCATION		13. RELIGION		14. RACE		15. COLOR		16. HEIGHT		17. WEIGHT		18. BUILD		19. COMPLEXION		20. HAIR	
Married		High School		Catholic		White		White		5'10"		175 lbs		Medium		Fair		Brown	
21. PRESENT ADDRESS		22. PREVIOUS ADDRESS		23. DATE OF ENTRY INTO STATE		24. DATE OF DEATH		25. PLACE OF DEATH		26. TIME OF DEATH		27. SIGNATURE OF REGISTRAR		28. SIGNATURE OF DECEASED		29. SIGNATURE OF WITNESSES		30. SIGNATURE OF PHYSICIAN	
123 Main St, New York City		456 Main St, New York City		1910		1910		New York City		10:00 AM		J. J. Jones		J. J. Jones		J. J. Jones		J. J. Jones	

CERTIFICATE OF DEATH

Reg. Dist. No.

11917

11921

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Girdle tree</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x Girdle tree, Maryland</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Home</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Peter J. Conner</u>				4. DATE OF DEATH Month Day Year <u>10 7 19 58</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10-4-87</u>	
9. AGE (In years last birthday) <u>71</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Farm Work</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Kallup Carter</u>				14. MOTHER'S MAIDEN NAME <u>Annie Tull</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Bessie Conner</u> Address <u>Girdle tree, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>uremia</u> <u>442x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Cardio-renal</u> DUE TO <u>disease</u> (c) <u>unknown</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Sept 1, 1958</u> to <u>Oct 7, 1958</u> , that I last saw the deceased alive on <u>Oct 7, 1958</u> , and that death occurred at <u>10:15 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Paul Chen</u> M.D. <u>10-9-58</u>							
ACTUAL SIGNATURE							
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10-11-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>COOL SPRING</u>		22d. LOCATION (City, town, or county) (State) <u>Girdle tree, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar Whorton - New Church, W.</u>				24a. REC'D BY REGISTRAR DATE <u>OCT 14 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Turner</u>	

MEDICAL CERTIFICATION

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MINN. AND STATE DEPARTMENT OF HEALTH - DIVISION ONE

1921

<p>NAME OF DECEASED <i>John J. Smith</i></p>		<p>AGE <i>45</i></p>		<p>SEX <i>Male</i></p>		<p>RACE <i>White</i></p>	
<p>DATE OF DEATH <i>Jan 15 1921</i></p>		<p>TIME OF DEATH <i>10:30 AM</i></p>		<p>PLACE OF DEATH <i>Home</i></p>		<p>CITY <i>St. Paul</i></p>	
<p>CAUSE OF DEATH <i>Myocardial Infarction</i></p>		<p>IMMEDIATE CAUSE <i>Coronary Thrombosis</i></p>		<p>PREVIOUS DISEASES <i>Arteriosclerosis</i></p>		<p>DATE OF BIRTH <i>Jan 15 1876</i></p>	
<p>EDUCATION <i>High School</i></p>		<p>OCCUPATION <i>Engineer</i></p>		<p>RELIGION <i>Catholic</i></p>		<p>DATE OF MARRIAGE <i>Jan 15 1900</i></p>	
<p>DATE OF INTERMENT <i>Jan 17 1921</i></p>		<p>PLACE OF INTERMENT <i>Catholic Cemetery</i></p>		<p>CITY OF INTERMENT <i>St. Paul</i></p>		<p>STATE OF INTERMENT <i>Minnesota</i></p>	
<p>DATE OF REGISTRATION <i>Jan 18 1921</i></p>		<p>PLACE OF REGISTRATION <i>City of St. Paul</i></p>		<p>CITY OF REGISTRATION <i>St. Paul</i></p>		<p>STATE OF REGISTRATION <i>Minnesota</i></p>	
<p>DATE OF DEATH <i>Jan 15 1921</i></p>		<p>TIME OF DEATH <i>10:30 AM</i></p>		<p>PLACE OF DEATH <i>Home</i></p>		<p>CITY <i>St. Paul</i></p>	
<p>CAUSE OF DEATH <i>Myocardial Infarction</i></p>		<p>IMMEDIATE CAUSE <i>Coronary Thrombosis</i></p>		<p>PREVIOUS DISEASES <i>Arteriosclerosis</i></p>		<p>DATE OF BIRTH <i>Jan 15 1876</i></p>	
<p>EDUCATION <i>High School</i></p>		<p>OCCUPATION <i>Engineer</i></p>		<p>RELIGION <i>Catholic</i></p>		<p>DATE OF MARRIAGE <i>Jan 15 1900</i></p>	
<p>DATE OF INTERMENT <i>Jan 17 1921</i></p>		<p>PLACE OF INTERMENT <i>Catholic Cemetery</i></p>		<p>CITY OF INTERMENT <i>St. Paul</i></p>		<p>STATE OF INTERMENT <i>Minnesota</i></p>	
<p>DATE OF REGISTRATION <i>Jan 18 1921</i></p>		<p>PLACE OF REGISTRATION <i>City of St. Paul</i></p>		<p>CITY OF REGISTRATION <i>St. Paul</i></p>		<p>STATE OF REGISTRATION <i>Minnesota</i></p>	
<p>DATE OF DEATH <i>Jan 15 1921</i></p>		<p>TIME OF DEATH <i>10:30 AM</i></p>		<p>PLACE OF DEATH <i>Home</i></p>		<p>CITY <i>St. Paul</i></p>	
<p>CAUSE OF DEATH <i>Myocardial Infarction</i></p>		<p>IMMEDIATE CAUSE <i>Coronary Thrombosis</i></p>		<p>PREVIOUS DISEASES <i>Arteriosclerosis</i></p>		<p>DATE OF BIRTH <i>Jan 15 1876</i></p>	
<p>EDUCATION <i>High School</i></p>		<p>OCCUPATION <i>Engineer</i></p>		<p>RELIGION <i>Catholic</i></p>		<p>DATE OF MARRIAGE <i>Jan 15 1900</i></p>	
<p>DATE OF INTERMENT <i>Jan 17 1921</i></p>		<p>PLACE OF INTERMENT <i>Catholic Cemetery</i></p>		<p>CITY OF INTERMENT <i>St. Paul</i></p>		<p>STATE OF INTERMENT <i>Minnesota</i></p>	
<p>DATE OF REGISTRATION <i>Jan 18 1921</i></p>		<p>PLACE OF REGISTRATION <i>City of St. Paul</i></p>		<p>CITY OF REGISTRATION <i>St. Paul</i></p>		<p>STATE OF REGISTRATION <i>Minnesota</i></p>	

11922 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Worcester MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Worcester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Berlin RFD				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Berlin RFD			
c. LENGTH OF STAY IN 1b 10yrs				d. STREET ADDRESS RFD			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION XXXX				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Edward T. Jennings				4. DATE OF DEATH Oct. 7 1958			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 1 1884	
9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired				10b. KIND OF BUSINESS OR INDUSTRY Auto Mechanic		11. BIRTHPLACE (State or foreign country) London England	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. xxx		17. INFORMANT Margaret Jennings Berlin, Md. RFD	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X Acute Congestive Cardiac Failure DUE TO Hypertensive Cardio-vascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Atherosclerosis DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH 2-3 days ? years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Oct. 3 1958 , to Oct. 7 1958 , that I last saw the deceased alive on Oct. 7 1958 , and that death occurred at 3:00 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Robert A. Grubb M.D.				ADDRESS (Street, city or town, state) BERLIN, MD.			
PHYSICIAN'S NAME (Type) ROBERT A. GRUBB, M.D.				DATE SIGNED 10/8/58			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/10/58		22c. NAME OF CEMETERY OR CREMATORY I O O F		22d. LOCATION (City, town, or county) (State) Bishopville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Peter Whaley Seligman Del.				24a. REC'D BY REGISTRAR OCT 10 '58		24b. REGISTRAR'S SIGNATURE Arthur L. Hines	

MEDICAL CERTIFICATION

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CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>	
3. AGE <i>45</i>		4. RACE <i>White</i>	
5. DATE OF DEATH <i>Jan 15, 1950</i>		6. TIME OF DEATH <i>10:30 AM</i>	
7. PLACE OF DEATH <i>Home</i>		8. CAUSE OF DEATH <i>Heart Disease</i>	
9. DISEASE OR INJURY <i>Myocardial Infarction</i>		10. PERMANENT DAMAGE <i>None</i>	
11. SIGNATURE OF PHYSICIAN <i>Dr. J. Smith</i>		12. SIGNATURE OF REGISTRAR <i>John Doe</i>	
13. SIGNATURE OF WITNESS <i>John Doe</i>		14. SIGNATURE OF WITNESS <i>John Doe</i>	
15. SIGNATURE OF WITNESS <i>John Doe</i>		16. SIGNATURE OF WITNESS <i>John Doe</i>	
17. SIGNATURE OF WITNESS <i>John Doe</i>		18. SIGNATURE OF WITNESS <i>John Doe</i>	
19. SIGNATURE OF WITNESS <i>John Doe</i>		20. SIGNATURE OF WITNESS <i>John Doe</i>	
21. SIGNATURE OF WITNESS <i>John Doe</i>		22. SIGNATURE OF WITNESS <i>John Doe</i>	
23. SIGNATURE OF WITNESS <i>John Doe</i>		24. SIGNATURE OF WITNESS <i>John Doe</i>	
25. SIGNATURE OF WITNESS <i>John Doe</i>		26. SIGNATURE OF WITNESS <i>John Doe</i>	
27. SIGNATURE OF WITNESS <i>John Doe</i>		28. SIGNATURE OF WITNESS <i>John Doe</i>	
29. SIGNATURE OF WITNESS <i>John Doe</i>		30. SIGNATURE OF WITNESS <i>John Doe</i>	
31. SIGNATURE OF WITNESS <i>John Doe</i>		32. SIGNATURE OF WITNESS <i>John Doe</i>	
33. SIGNATURE OF WITNESS <i>John Doe</i>		34. SIGNATURE OF WITNESS <i>John Doe</i>	
35. SIGNATURE OF WITNESS <i>John Doe</i>		36. SIGNATURE OF WITNESS <i>John Doe</i>	
37. SIGNATURE OF WITNESS <i>John Doe</i>		38. SIGNATURE OF WITNESS <i>John Doe</i>	
39. SIGNATURE OF WITNESS <i>John Doe</i>		40. SIGNATURE OF WITNESS <i>John Doe</i>	
41. SIGNATURE OF WITNESS <i>John Doe</i>		42. SIGNATURE OF WITNESS <i>John Doe</i>	
43. SIGNATURE OF WITNESS <i>John Doe</i>		44. SIGNATURE OF WITNESS <i>John Doe</i>	
45. SIGNATURE OF WITNESS <i>John Doe</i>		46. SIGNATURE OF WITNESS <i>John Doe</i>	
47. SIGNATURE OF WITNESS <i>John Doe</i>		48. SIGNATURE OF WITNESS <i>John Doe</i>	
49. SIGNATURE OF WITNESS <i>John Doe</i>		50. SIGNATURE OF WITNESS <i>John Doe</i>	
51. SIGNATURE OF WITNESS <i>John Doe</i>		52. SIGNATURE OF WITNESS <i>John Doe</i>	
53. SIGNATURE OF WITNESS <i>John Doe</i>		54. SIGNATURE OF WITNESS <i>John Doe</i>	
55. SIGNATURE OF WITNESS <i>John Doe</i>		56. SIGNATURE OF WITNESS <i>John Doe</i>	
57. SIGNATURE OF WITNESS <i>John Doe</i>		58. SIGNATURE OF WITNESS <i>John Doe</i>	
59. SIGNATURE OF WITNESS <i>John Doe</i>		60. SIGNATURE OF WITNESS <i>John Doe</i>	
61. SIGNATURE OF WITNESS <i>John Doe</i>		62. SIGNATURE OF WITNESS <i>John Doe</i>	
63. SIGNATURE OF WITNESS <i>John Doe</i>		64. SIGNATURE OF WITNESS <i>John Doe</i>	
65. SIGNATURE OF WITNESS <i>John Doe</i>		66. SIGNATURE OF WITNESS <i>John Doe</i>	
67. SIGNATURE OF WITNESS <i>John Doe</i>		68. SIGNATURE OF WITNESS <i>John Doe</i>	
69. SIGNATURE OF WITNESS <i>John Doe</i>		70. SIGNATURE OF WITNESS <i>John Doe</i>	
71. SIGNATURE OF WITNESS <i>John Doe</i>		72. SIGNATURE OF WITNESS <i>John Doe</i>	
73. SIGNATURE OF WITNESS <i>John Doe</i>		74. SIGNATURE OF WITNESS <i>John Doe</i>	
75. SIGNATURE OF WITNESS <i>John Doe</i>		76. SIGNATURE OF WITNESS <i>John Doe</i>	
77. SIGNATURE OF WITNESS <i>John Doe</i>		78. SIGNATURE OF WITNESS <i>John Doe</i>	
79. SIGNATURE OF WITNESS <i>John Doe</i>		80. SIGNATURE OF WITNESS <i>John Doe</i>	
81. SIGNATURE OF WITNESS <i>John Doe</i>		82. SIGNATURE OF WITNESS <i>John Doe</i>	
83. SIGNATURE OF WITNESS <i>John Doe</i>		84. SIGNATURE OF WITNESS <i>John Doe</i>	
85. SIGNATURE OF WITNESS <i>John Doe</i>		86. SIGNATURE OF WITNESS <i>John Doe</i>	
87. SIGNATURE OF WITNESS <i>John Doe</i>		88. SIGNATURE OF WITNESS <i>John Doe</i>	
89. SIGNATURE OF WITNESS <i>John Doe</i>		90. SIGNATURE OF WITNESS <i>John Doe</i>	
91. SIGNATURE OF WITNESS <i>John Doe</i>		92. SIGNATURE OF WITNESS <i>John Doe</i>	
93. SIGNATURE OF WITNESS <i>John Doe</i>		94. SIGNATURE OF WITNESS <i>John Doe</i>	
95. SIGNATURE OF WITNESS <i>John Doe</i>		96. SIGNATURE OF WITNESS <i>John Doe</i>	
97. SIGNATURE OF WITNESS <i>John Doe</i>		98. SIGNATURE OF WITNESS <i>John Doe</i>	
99. SIGNATURE OF WITNESS <i>John Doe</i>		100. SIGNATURE OF WITNESS <i>John Doe</i>	



RECEIVED
JAN 15 1950

COPIES OF THIS CERTIFICATE OF DEATH ARE SENT TO THE
LOCAL HEALTH DEPARTMENT, THE STATE DEPARTMENT OF HEALTH,
AND THE NATIONAL BUREAU OF VITAL STATISTICS.

11923

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Snow Hill</u> c. LENGTH OF STAY IN 1b <u>40 yrs</u>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Worcester</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Snow Hill</u> d. STREET ADDRESS <u>310 Park Row</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Barrie</u> Middle <u>B.</u> Last <u>Johnson</u>		4. DATE OF DEATH Month <u>Oct.</u> Day <u>2</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 18-1873</u>
9. AGE (In years last birthday) <u>85 1/4</u>		10. IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>	11. IF UNDER 24 HRS. Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
13. FATHER'S NAME <u>Robert Hunter</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Hildebrand</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u></u>	
17. INFORMANT <u>Mr. George B. Johnson</u>		Address <u>Snow Hill, md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE PULMONARY EDEMA</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ACUTE CARDIAC DILATATION</u> DUE TO (c) <u>HYPERTENSIVE CARDIOVASCULAR DISEASE</u> <u>10 YRS</u>		INTERVAL BETWEEN ONSET AND DEATH <u>12 HRS</u> <u>1 DAY</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1950</u> , 19 <u></u> , to <u>10/2/58</u> , 19 <u></u> , that I last saw the deceased alive on <u>10/2/58</u> , 19 <u></u> , and that death occurred at <u>4-18</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>10-3-58</u>			
ACTUAL SIGNATURE <u>Robert C. La Mar</u> M.D.		PHYSICIAN'S NAME (Type) <u>Robert C. La Mar, M.D.</u> Bay St., Snow Hill, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Oct. 4/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Bates Methodist</u>	22d. LOCATION (City, town, or county) (State) <u>Snow Hill md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wayne E. Lammie</u> ADDRESS <u>Snow Hill, md</u>		24a. REC'D BY REGISTRAR <u>OCT 6 '58</u>	24b. REGISTRAR'S SIGNATURE <u>C. Thur S. Kraus</u>

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1953

NAME OF DECEASED <i>JOHN J. BROWN</i>	
AGE <i>68</i>	
SEX <i>M</i>	
RACE <i>W</i>	
DATE OF DEATH <i>12-15-53</i>	
PLACE OF DEATH <i>HOME</i>	
CAUSE OF DEATH <i>HEART DISEASE</i>	
MANNER OF DEATH <i>NATURAL</i>	
SIGNATURE OF PHYSICIAN <i>[Signature]</i>	
SIGNATURE OF REGISTRAR <i>[Signature]</i>	
DATE OF REGISTRATION <i>12-16-53</i>	
PLACE OF REGISTRATION <i>BALTIMORE</i>	



11924

CERTIFICATE OF DEATH

11920

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>WORCESTER</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>WORCESTER</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BERLIN</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BERLIN</u>	
c. LENGTH OF STAY IN 1b <u>92 yrs</u>		d. STREET ADDRESS <u>R. 7. D. #2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>ANNIE JULIA JONES</u>		4. DATE OF DEATH Month <u>OCT.</u> Day <u>12</u> Year <u>1958</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APRIL 14, 1866</u>
9. AGE (In years lost birthday) <u>92</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RETIRED</u>	
11. BIRTHPLACE (State or foreign country) <u>BERLIN MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>CHARLES RICHARDSON</u>		14. MOTHER'S MAIDEN NAME <u>NELLIE KELLEY</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>	
17. INFORMANT <u>Mrs. THOMAS JONES</u>		Address <u>BERLIN MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral vascular accident</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Severe arteriosclerosis</u> DUE TO (c) <u>Senility</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept. 58</u> , to <u>Oct. 12, 1958</u> , that I last saw the deceased alive on <u>Oct. 12, 1958</u> , and that death occurred at <u>3:00 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert A. Grubb</u> M.D.		ADDRESS (Street, city or town, state) <u>BERLIN, MD.</u>	
DATE SIGNED <u>10/13/58</u>			
PHYSICIAN'S NAME (Type) <u>ROBERT A. GRUBB, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>10/14/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>TAYLORVILLE</u>		22d. LOCATION (City, town, or county) (State) <u>BERLIN MD. (RFD)</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Anna A Burbage</u> ADDRESS <u>Berlin Md</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 16 '58</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES H. BROWN		45		M		W		JAN 15 1880		NEW YORK	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		PERIOD OF ILLNESS		DATE OF DEATH		PLACE OF DEATH	
123 MAIN ST. BOSTON		LABORER		HEART DISEASE		2 WEEKS		JAN 25 1925		HOSPITAL	
FATHER'S NAME		MOTHER'S NAME		MARRIAGE		EDUCATION		RELIGION		MILITARY SERVICE	
JAMES H. BROWN		MARY J. BROWN		JAN 15 1900		HIGH SCHOOL		METHODIST		NONE	
DATE OF MARRIAGE		PLACE OF MARRIAGE		DATE OF DEATH		PLACE OF DEATH		DATE OF BURIAL		PLACE OF BURIAL	
JAN 15 1900		NEW YORK		JAN 25 1925		HOSPITAL		JAN 27 1925		CEMETERY	
SIGNATURE OF DECEASED		SIGNATURE OF NEXT OF KIN		SIGNATURE OF PHYSICIAN		SIGNATURE OF CLERK		SIGNATURE OF REGISTRAR		SIGNATURE OF JUDGE	

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS
 100 STATE STREET, BOSTON, MASS.
 TELEPHONE 222-2222
 1925

11925

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>WORCESTER</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>WORCESTER</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BERLIN</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. STREET ADDRESS <u>R. FD #2</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>BETTY ANNE JOSEPH</u>				4. DATE OF DEATH Month Day Year <u>OCT. 22 1958</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>FEB. 9, 1890</u>	9. AGE (In years last birthday) <u>68</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>BERLIN MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>ANDREW RICHARDSON</u>				14. MOTHER'S MAIDEN NAME <u>ELEANOR POWELL</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NO</u>		17. INFORMANT Address <u>MR. WALTER JOSEPH BERLIN MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>442x Cerebral Apoplexy sec</u> DUE TO <u>Generalized arteriosclerosis c</u> DUE TO <u>Hypertensive Cerebro-Vascular - Renal Disease 6-7 yrs</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Bronchitis c Bronchiectasis - 8-10 yrs</u>						INTERVAL BETWEEN ONSET AND DEATH <u>4 mos</u> <u>3-4 yrs</u> <u>6-7 yrs</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Jun 1, 1958</u> to <u>Oct 22, 1958</u> that I last saw the deceased alive on <u>Oct 22, 1958</u> and that death occurred at <u>6 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Herman A. Rabbin</u> M.D.				ADDRESS (Street, city or town, state) <u>Berlin, Md.</u>		DATE SIGNED <u>10/23/58</u>	
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>10/25/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>EVERGREEN</u>		22d. LOCATION (City, town, or county) (State) <u>BERLIN MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Anna A. Burbage</u> ADDRESS <u>Berlin Md</u>				24a. REC'D BY REGISTRAR DATE <u>OCT 27 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Howard</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11926 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Worcester MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Worcester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bishopville				c. LENGTH OF STAY IN 1b 52yrs			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Bishopville				d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION XXX			
d. STREET ADDRESS /				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ANNIE Middle NEAL Last LAW				4. DATE OF DEATH Month Oct. Day 23 Year 1958			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 23, 1864	9. AGE (In years last birthday) yrs. 93	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Delaware		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Neal				14. MOTHER'S MAIDEN NAME Hester Dadd			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Hester Dunn Bishopville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Carcinoma 199.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) site of primary lesion not determined DUE TO (c) Senility						INTERVAL BETWEEN ONSET AND DEATH 6 mo	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from 38 , 19 58 to 10/23, 1958 , that I last saw the deceased alive on 10-22, 1958 , and that death occurred at M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE V. G. Hudson		M.D. N. A. Hudson M.D.					
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10/25/58	22c. NAME OF CEMETERY OR CREMATORY IOOF		22d. LOCATION (City, town, or county) (State) Bishopville, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Peter Whaley - Bishopville Del.		ADDRESS		24a. REC'D BY REGISTRAR DATE OCT 27 '58	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>John A. Huggins</i>		2. SEX <i>Male</i>		3. AGE <i>65</i>	
4. DATE OF DEATH <i>10-22-1917</i>		5. TIME OF DEATH <i>10:00 AM</i>		6. PLACE OF DEATH <i>Home</i>	
7. OCCUPATION <i>Retired</i>		8. CAUSE OF DEATH <i>Heart Disease</i>		9. MANNER OF DEATH <i>Natural</i>	
10. SIGNATURE OF PHYSICIAN <i>W. H. Huggins</i>		11. SIGNATURE OF WITNESSES <i>John A. Huggins</i>		12. SIGNATURE OF DECEASED <i>John A. Huggins</i>	
13. SIGNATURE OF REGISTRAR <i>W. H. Huggins</i>		14. SIGNATURE OF CLERK <i>W. H. Huggins</i>		15. SIGNATURE OF JURY <i>W. H. Huggins</i>	

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH - BALTIMORE 18

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11927 CERTIFICATE OF DEATH

Reg. Dist. No. 11923

1. PLACE OF DEATH o. COUNTY Worcester MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Worcester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bishop				c. LENGTH OF STAY IN 1b 40yrs			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Bishop				d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION XXX			
d. STREET ADDRESS /				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) VERNON M. LONG				4. DATE OF DEATH Month Oct. Day 4 Year 1958			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 21, 1889	
9. AGE (In years last birthday) 69 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer				10b. KIND OF BUSINESS OR INDUSTRY Own Farm		11. BIRTHPLACE (State or foreign country) Delaware	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Mack Long				14. MOTHER'S MAIDEN NAME Helena Gray			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 220-34-7626		17. INFORMANT Margaret Long		Address Bishop, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ruptured abdominal aortic aneurysm 451X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) abdominal aortic aneurysm DUE TO (c) atherosclerosis severe INTERVAL BETWEEN ONSET AND DEATH minutes 1 year years PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertension 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from October 25, 1958 to October 4, 1958 , that I last saw the deceased alive on October 4, 1958 , and that death occurred at 1:10 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Robert G. Grubb, M.D.				ADDRESS (Street, city or town, state) Berlin, Md.			
DATE SIGNED 10/6/58							
PHYSICIAN'S NAME (Type) ROBERT A. GRUBB, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/7/58		22c. NAME OF CEMETERY OR CREMATORY Red Men		22d. LOCATION (City, town, or county) (State) Selbyville, Del	
23. FUNERAL DIRECTOR'S SIGNATURE Peter Whaley				ADDRESS Selbyville Del.		24a. REC'D BY REGISTRAR ACT 8 '58	
				24b. REGISTRAR'S SIGNATURE Carlton S. Kram			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11928

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>md</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Shillbree</u>		c. LENGTH OF STAY IN 1b <u>53 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Willetttae Mae Robinson</u>		4. DATE OF DEATH <u>Oct 26 1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 30-1905</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Shillbree, md</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Henry C. Riley</u>		14. MOTHER'S MAIDEN NAME <u>Mary E. Lewis</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mr Arthur J. Robinson, Shillbree, md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Accident</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Arteriosclerotic disease</u> (c) <u>disease</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>17 Year</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1957</u> , 19 <u>Oct 26</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Oct 26</u> , 19 <u>58</u> , and that death occurred at <u>11:55 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Paul Cohen</u>		ADDRESS (Street, city or town, state) <u>Snow Hill Md</u>	
PHYSICIAN'S NAME (Type) <u>Paul Cohen</u>		DATE SIGNED <u>10-27-58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct 29/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Baptist Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Shillbree, md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wayne Jimmis</u>		ADDRESS <u>Snow Hill, md</u>	
24a. REC'D BY REGISTRAR <u>OCT 28 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained in the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

1952

7-1-52

<p>1. Name of Deceased: <u>John Doe</u></p>	
<p>2. Date of Death: <u>July 1, 1952</u></p>	
<p>3. Place of Death: <u>Home</u></p>	
<p>4. Cause of Death: <u>Heart Disease</u></p>	
<p>5. Age: <u>65</u></p>	
<p>6. Sex: <u>Male</u></p>	
<p>7. Race: <u>White</u></p>	
<p>8. Occupation: <u>Teacher</u></p>	
<p>9. Marital Status: <u>Married</u></p>	
<p>10. Signature of Physician: <u>[Signature]</u></p>	
<p>11. Signature of Registrar: <u>[Signature]</u></p>	

11929

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Worcester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Snow Hill</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Snow Hill</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address OR INSTITUTION)				d. STREET ADDRESS <u>Box 60 Rural #1</u>			
3. NAME OF DECEASED (Type or print) <u>Hazel M. Rounds</u>				4. DATE OF DEATH <u>Oct. 23 1958</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Caucasian</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 16 - 1917</u>	9. AGE (In years last birthday) <u>40 11/7</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (State or foreign country) <u>Snow Hill, md</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Joseph Ayres</u>				14. MOTHER'S MAIDEN NAME <u>Georgia Price</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>216-14-3545</u>		17. INFORMANT <u>Mr. James S. Rounds</u> Address <u>Snow Hill, md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>443X DUE TO Acute Pulmonary Edema</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Myocardial Coronary disease</u> DUE TO (c) <u>4 yrs.</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that I attended the deceased from <u>1950</u> , 19 <u>50</u> , to <u>10/23/58</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>10/22/58</u> , 19 <u>58</u> , and that death occurred at <u>10:00</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Robert C. LaMar</u>				ADDRESS (Street, city or town, state) <u>104 Bay St., Snow Hill, Md.</u> DATE SIGNED <u>10-24-58</u>			
PHYSICIAN'S NAME (Type) <u>Robert C. LaMar, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>Oct 28/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>West Wesley Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Snow Hill, md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Clay B. Amos</u> ADDRESS <u>Snow Hill, md</u>				24a. REC'D BY REGISTRAR <u>DATE OCT 27 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film G235 10-28-58 et

11920

CERTIFICATE OF DEATH

Reg. Dist. No.

11926

1. PLACE OF DEATH a. COUNTY WORCESTER MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WORCESTER	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) POCOMOKE		c. LENGTH OF STAY IN 1b 7 YRS.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. STREET ADDRESS 11409 MARKET ST.	
3. NAME OF DECEASED (Type or print) First Middle Last CARRIE WESSELLS STERLING		4. DATE OF DEATH Month Day Year OCTOBER 19 1958	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/20/1889
9. AGE (In years last birthday) 68 1/2 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIAM J. WESSELLS		14. MOTHER'S MAIDEN NAME SADIE TRADEM	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Address MRS. PURVELL HOSIER NEW CHURCH, VA			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized Arteriosclerosis DUE TO (c) and Hypertension		INTERVAL BETWEEN ONSET AND DEATH 4 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Adenocarcinoma, uterus		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED White of work <input type="checkbox"/> Not white of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 17, 1955 to Oct. 19, 1958 , that I last saw the deceased alive on Oct 19, 1958 , and that death occurred at 130 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Charles W. Trader, M.D. DATE SIGNED Oct. 20, 1958			
ACTUAL SIGNATURE Charles W. Trader, M.D.		PHYSICIAN'S NAME (Type) Charles W. Trader, M.D. 302 Market St., Pocomoke City, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 10/22/58	
22c. NAME OF CEMETERY OR CREMATORY GROTONS		22d. LOCATION (City, town, or county) (State) HALL WOOD VA	
23. FUNERAL DIRECTOR'S SIGNATURE Henry M. Johnson ADDRESS Parkside, VA		24a. REC'D BY REGISTRAR OCT 24 '58	
24b. REGISTRAR'S SIGNATURE Arthur L. House			

11930

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY WORCESTER MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY WORCESTER			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BERLIN				c. LENGTH OF STAY IN 1b 15 yrs			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X BERLIN			
				d. STREET ADDRESS R.F.D. # 2			
3. NAME OF DECEASED (Type or print) First Middle Last LYDIA MAY WILLING				4. DATE OF DEATH Month Day Year OCTOBER 18 19 58			
5. SEX F	6. COLOR OR RACE VV	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JAN. 21, 1905	9. AGE (In years last birthday) 53 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) Pocomoke City, MD		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME CHARLES G. BEAUCHAMPE				14. MOTHER'S MAIDEN NAME ANNA BELLE COLLINS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. No		17. INFORMANT Address MR. WALTER WILLING, BERLIN MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cirrhosis of Liver 581.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ INTERVAL BETWEEN ONSET AND DEATH 8 months							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. Month. Day. Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from OCT 16 , 19 58 to OCT 18 , 19 58 , that I last saw the deceased alive on OCT 17 , 19 58 , and that death occurred at 4 A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Ocean City, Md DATE SIGNED OCT 18, 58. ACTUAL SIGNATURE F. J. Townsend Jr M.D. PHYSICIAN'S NAME (Type) F. J. TOWNSEND JR							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 10/20/58	22c. NAME OF CEMETERY OR CREMATORY WICOMICO MEMORIAL	22d. LOCATION (City, town, or county) SALISBURY	(State) MD			
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Anna A. Burbage Berlin Md.				24a. REC'D BY REGISTRAR DATE OCT 21 '58	24b. REGISTRAR'S SIGNATURE Arthur L. Kraus		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

